Bellevue Hospital CenterBellevue Hospital CenterBellevue Hospital CenterBellevue
Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd
Formulation (WP) : ON ADMISSION 6/19/12:
26 yo AAM with reported hx of schizophrenia and prior inpat treatment, arrested in april 2012 for alleged attempted murder of an officer [stabbing] who was called to his home by him and/or his mother, admitted in April while under NYPD custody to 19N, referred back to Bellevue because of concerns about agitation and lability. Pt has a significant history of psychiatric treatment as well as poor impulse control and prior trials of mult medications. During his admissions to 19N in April, he was oddly related at times and showed poor impulse control. There appears to be elements of both Axis I and Axis II traits. Per referral, pt has been difficult to manage at the jail, and pt is now agreeing that he would benefit from medication adjustment to address his impulse control. As such, will sign pt in 9.13. Of note, I encouraged pt to comply with tx team and to approach tx team in a calm and controlled manner with any problems, such as if he changes his mind and wants discharge [pt was able to be discharged last time after he requested discharge and showed a period of controlled behavior]. Risk of harm to self is considered low at this time - pt denies hx of suicidal behavior. However, he has risk factors such as social isolation and hopelessness about his attempted murder charge and possible conviction. Risk of harm to others is considered low to moderate right now but moderate to high/moderate in general - pt has history of drug abuse, violence and arrest, with what appears to be little regard for the feelings of others [as observed throughout the time on 19N]. However, right now he is calm and complying with admission procedures, agreeing with admission.

ON DISCHARGE 7/1/12:
26yo AAM charged with alleged Attempted Murder of a Police Officer stemming from events in April 2012 that were highly publicized at the time, with history of multiple psychiatric hospitalizations since age 18

Bellevue Hospital CenterBellevue Hospital CenterBellevue Hospital CenterBellevue
Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

in the context of aggression and paranoia, violence both while hospitalized and in the community, substance use, known to 19N from two brief admissions shortly after arrest. He returned to 19W on 6/19 for voluntary admission after being referred from Rikers for "extreme lability" and threatening behavior. During his two weeks on the unit, he has been terse and guarded, as well as oddly related, with an odd smile at times, and is irritable at other times. However, he has been calm, coherent, logical, organized, and not overtly psychotic, manic, depressed, or anxious. He explained that his agitation at Rikers prior to admission was triggered by the fact that his housing had been changed recently, which caused him to feel that he was being provoked. He expressed feeling frustrated and stressed by his legal situation, and spoke about feeling targeted by others in the jail setting due to his high-profile charges. While these statements may reflect paranoid ideation, they may also have a basis in reality given the nature of his case. At any rate, he has been minimally engaged in individual psychotherapy or in therapeutic groups. He has accepted his standing medication and voices feeling "better" than on admission.

Diagnostically, collateral information gathered on prior admissions to 19N and from the patient's mother during this admission indicates a history of diagnosis with psychotic illness, specifically Schizophrenia, Paranoid Type. During the current admission no overt signs of acute psychosis or any other acute major mental illness were observed, however the patient reports he has been compliant with antipsychotic and mood-stabilizing medications for several weeks prior to admission and has remained compliant with that medication here. Therefore, it is possible that he is presenting with a symptom picture that is attenuated. Axis II is deferred at this time but Antisocial traits have been identified on past

Fri, 23 Aug 13 1128

ellevue Hospital CenterBellevue Hospital CenterBellevue Hospital CenterBellevue
Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19N-14-B	Hale,Terrance	3501306	3501306-1	27Y	M

Attending Physician: Roth,Loren
D.O.B.: 02/25/1986

Unscheduled Discharge Summary-Psych IP Status: complete
Event Time: Fri, 20 Apr 12 1218

Fri, 20 Apr 12 1229 Documented by Loren Roth, MD

Start Time of IP Assmnt: 18 Apr 12 1000
Source of Referral : Law enforcement
Sources of Information : Patient,Facility paper records
Barriers to Assessment : Patient unwilling,Patient unable
Consenting Party : patient consents or involuntary treatment
Preferred Language(s): English

From:

07/10/2013 13:04 #493 P.005/007

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we,

have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here: → Vearry Hale

ACKNOWLEDGMENT

State of New York, County of N.Y. ss:

On May 5, 2010 before me, the undersigned, personally appeared Vearry Hale

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

STEVEN EHRLICH
Notary Public, State of New York
No. 02EH6029973
Qualified in New York County
Commission Expires Sept. 27, 20 13

State of County of ss:

On before me, the undersigned, personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

AFFIDAVIT THAT POWER OF ATTORNEY IS IN FULL FORCE AND EFFECT

(Sign before a notary public)

STATE OF

COUNTY OF ss.:

being duly sworn, deposes and says:

1. The Principal appointed me as the Principal's true and lawful Agent in the within Power of Attorney.
2. I do not have, at the time of this transaction, actual notice of the termination or revocation of the power of attorney, or notice of any facts indicating that the power of attorney has been terminated or revoked;
3. I do not have, at the time of this transaction, actual notice that the power of attorney has been modified in any way that would affect my ability as the agent to authorize or engage in the transaction, or notice of any facts indicating that the power of attorney has been so modified; and
4. I make this affidavit for the purpose of inducing

to accept delivery of the following Instrument(s), as executed by me in my capacity as the Agent, with full knowledge that this affidavit will be relied upon in accepting the execution and delivery of the Instrument(s) and in paying good and valuable consideration therefor:

☐ *I am the successor agent, the prior agent is no longer or willing to serve.*

Sworn to before me on

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
TERRANCE HALE	12-25-1986	

Patient Address: 15-15 Hazen Queens NY / 1945 Third Ave. NYNY #10E 10029

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
New York City Health and Hospitals Corp., HHC BELLEVUE HOSPITAL

8. Name and address of person(s) or category of person to whom this information will be sent:
The Legal Aid Society, 199 Water Street 6th Fl., New York, NY 11370

9(a). Specific information to be released:
- ☐ Medical Record from (insert date) 1-17-2012 to (insert date) present
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)
- T.H **Alcohol/Drug Treatment**
- T.H **Mental Health Information**
- T.H **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here T.H (Initials) I authorize **New York City Health and Hospitals Corp., HHC** (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:
John Boston, Jonathan Chasan, Dale Wilker, The Legal Aid Society, 199 Water St., NY NY 10038
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
- ☑ At request of individual
- ☐ Other: mother/guardian/parent

11. Date or event on which this authorization will expire:
1/1/2015

12. If not the patient, name of person signing form:
Yearry Hale - mother

13. Authority to sign on behalf of patient:
mother; guardian; power of attorney

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Yearry Hale
Signature of patient or representative authorized by law.

Date: 7/15/13

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

M 51 — New York Statutory Power of Attorney: durable unless modified, with affidavit of attorney, GOL § 5-1513; 12 pt. type, 1-09

POWER OF ATTORNEY—NEW YORK STATUTORY SHORT FORM

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney by executing this Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

name and address of principal

I, Terrence Hale, 1945 3rd Avenue #10E; N.Y. 10029 hereby appoint:

name(s) and address(es) of agent(s)

Vearry Hale, 1945 3rd Avenue #10E, N.Y. 10029 as my agent(s)

If you designate more than one agent above, they must act together unless you initial the statement below.

[ ] My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)

If every agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

name(s) and address(es) of successor agent(s)

Successor agents designated above must act together unless you initial the statement below.

[ ] My successor agents may act SEPARATELY.

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications."

(e) This POWER OF ATTORNEY REVOKES any and all prior Powers of Attorney executed by me unless I have stated otherwise below, under "Modifications."

If you are NOT revoking your prior Powers of Attorney, and if you are granting the same authority in two or more Powers of Attorney, you must also indicate under "Modifications" whether the agents given these powers are to act together or separately.

(f) GRANT OF AUTHORITY:

To grant your agent some or all of the authority below, either

(1) Initial the bracket at each authority you grant, or

(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

[TH] (A) real estate transactions;
[TH] (B) chattel and goods transactions;
[TH] (C) bond, share, and commodity transactions;
[TH] (D) banking transactions;
[TH] (E) business operating transactions;
[TH] (F) insurance transactions;
[TH] (G) estate transactions;
[TH] (H) claims and litigation;
[TH] (I) personal and family maintenance;
[TH] (J) benefits from governmental programs or civil or military service;
[TH] (K) health care billing and payment matters; records, reports, and statements;
[TH] (L) retirement benefit transactions;
[TH] (M) tax matters;
[TH] (N) all other matters;
[TH] (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;
[TH] (P) EACH of the matters identified by the following letters A, B, C, D E, F, G, H, I, J, K L, M, N, O, P
You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent.

However, you cannot use this Modifications section to grant your agent authority to make major gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Major Gifts Rider.

(h) MAJOR GIFTS AND OTHER TRANSFERS: STATUTORY MAJOR GIFTS RIDER: (OPTIONAL)

In order to authorize your agent to make major gifts and other transfers of your property, you must initial the statement below and execute a Statutory Major Gifts Rider at the same time as this instrument.

Initialing the statement below by itself does not authorize your agent to make major gifts and other transfers. The preparation of the Statutory Major Gifts Rider should be supervised by a lawyer.

[ ] (SMGR) I grant my agent authority to make major gifts and other transfers of my property, in accordance with the terms and conditions of the Statutory Major Gifts Rider that supplements this Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL) I wish to designate

whose address(es) is (are)

as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation," you may do so above, under "Modifications."

[ ] My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION: This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name 20

PRINCIPAL signs here: → Terrance Hale

ACKNOWLEDGMENT

STATE OF NEW YORK COUNTY OF N.Y. ss.:

On May 5, 2010 before me, the undersigned, personally appeared

Terrance Hale

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

STEVEN EHRLICH
Notary Public, State of New York
No. 02EH6029973
Qualified in New York County
Commission Expires Sept. 27, 2013

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;

(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manner: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or give major gifts to yourself or anyone else unless the principal has specifically granted you that authority in this Power of Attorney or in a Statutory Major Gifts Rider attached to this Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest. You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent:

The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Appearance	:	Appears stated age,Adequately dressed,Adequate grooming
Behavior	:	Cooperative,Indifferent,Distant relatedness,Normal eye-contact,Normal psychomotor activity,No abnormal movements,Normal gait
Speech	:	Normal rate,Soft,Normal rhythm,Fluent,Non-pressured,Standard English accent
Thought Process	:	Goal directed,Concrete thinking
Thought Content	:	Normal content
Suicidal Ideation	:	No suicidal ideation
Aggressive Ideation	:	No aggressive or homicidal ideation
Perceptual Disorders	:	No perceptual disorders
Mood	:	Euthymic
Affect	:	Constricted,Stable affect
Impulse Control	:	Intact impulse control
Cognitive Function	:	Alert,Oriented x4
Insight	:	No grossly impaired insight
Judgment	:	No grossly impaired judgment

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

not demonstrate any self-injurious or aggressive behaviors at any time during this admission. He was observed while talking on the phone during several days of his hospital stay. He was quite verbal and showed full range of facial expressions, including smiling and laughing at times. When approached by hospital staff, he was mostly constricted and terse.

Medically, there we no acute issues addressed during this admission. He sustained a nasal bone fracture prior to admission and was evaluated and medically cleared at an outside hospital prior to admission. He was seen again at BHC and no surgical intervention was recommended. He did not complain of significant pain. Just prior to discharge, the patient complained of a toothache. Rikers staff was made aware to set up a dental clinic appointment should the toothache persist.

The case was conference with Rikers Island staff prior to his discharge. Due to the nature of his behavior at Rikers Island, he will be returned to GRVC instead of AMKC. He was deemed stable for discharge to Rikers on 7/19/12.

Discharge Medications:
Prolixin Decanoate 25 mg IM q2weeks
Depakote 500 mg qAM, 1000 mg qPM
Trazodone 100 mg at bedtime.

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19N-14-B	Hale,Terrance	3501306	3501306-1	27Y	M

Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

and unmarried with two children (ages 3 and 5 according to patient). He has a history of 5 or 6 psychiatric hospitalizations including one state hospitalization since the age of 16/17, a history of a recent outpatient psychiatric evaluation at St. Mark's Clinic, and a history of multiple arrests for violent behavior, which led to one state prison incarceration from 5/2007 - 3/2008 (charges of Assault). His substance use history is presently unknown. The patient was arrested on or about 4/17/12; according to records Mr. Hale's mother called 911 seeking hospitalization for Mr. Hale, and when police arrived Mr. Hale is alleged to have stabbed a police officer in the temple, causing a severe, penetrating injury requiring surgery. Mr. Hale was taken to Metropolitan Hospital Center (MHC), where he was observed to be internally preoccupied, and referred for forensic psychiatric admission at BHC. At BHC CPEP, Mr. Hale presented as sullen and irritable. While in CPEP Mr. Hale initially refused to answer any questions, but eventually stated that he has a past diagnosis of paranoid schizophrenia, though he does not believe he suffers from a mental illness. He denied all symptoms of mental illness, including depressed mood, AH/VH/SI/HI, and no delusions were elicited. He provided that he asked his mother to call the ambulance because he has not been able to sleep for several days and was feeling exhausted. Also while in CPEP, Mr. Hale became agitated and received Seroquel 100mg po, and later Ativan 2mg IM. The patient was admitted to 19N, and there were no incidents overnight.

On inpatient reassessment the morning of

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Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

4/18/12, Mr. Hale presented as irritable and uncooperative, and there were no over signs of psychosis. He initially refused to meet with the treatment team, but eventually agreed after being allowed a few more minutes to sleep. The patient was unwilling to answer many of the team's questions, citing his having recently answered the same questions in CPEP. As on evaluation in CPEP, Mr. Hale denied all symptoms of mental illness, including AH/VH/SI/HI, and depressed mood. He did provide that he has been "tired," and had not been sleeping well recently. He also stated that he was living with his mother and two daughters (ages 3 and 5) in Spanish Harlem. He provided verbal consent for clinicians to contact his mother, Vearry Hale, and his outpatient psychiatrist, Dr. Nunes at St. Mark's Clinic. The team was unable to conduct a complete and thorough interview and assessment of Mr. Hale, as he became irritable and left the room.

According to the patient's mother, Mr. Hale has been living with her, and his daughters live with his girlfriend in Queens. Medically, Mrs. Hale stated that Mr. Hale has a history of diabetes, particularly in conjunction with psychiatric medication. Mrs. Hale explained that Mr. Hale has a history of psychiatric medications that includes Thorazine, Depakote, and a medication to combat "shaking," and he has presently been taking Latuda 80mg. He had recently been prescribed Latuda 40mg by Dr. Nunes at the St. Mark's Clinic, but Mrs. Hale felt that this was not adequate, and began giving her son the medication of a stronger dosage that was left over from a

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Chart Review Print

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Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

these medications about a month ago and was switched to Latuda originally 80mg/day, but more recently has only been prescribed 40mg/day. Mother stated that patient was diagnosed at one point with DMII but she believes that this was medication-induced and he currently does not take andy diabetes medications and does not follow a diabetic diet. Mother stated that she administers the medication and that patient has been taking it. The injured police officer was reportedly stabbed in the temple area with brain penetration, has a sericus facial laceration and other injuries and underwent surgery at MSMC. This story has already been in multiple media reports. Patient states that he has been diagnosed with paranoid schizophrenia and that he does not believe that he suffers from this. He denies paranoia, denies (A)/(V)hallS, denies SI/paraSI and denies HI/aggressive ideation at this time. No delusions were elicited. Patient states that he did ask his mother to call for the ambulance because he has not been able to sleep for several days and he was feeling very exhausted. Patient states that he has not been feeling particularly depressed of late. Patient appeared very sullen. Patient also appears very pent up at the same time and became very irritable with police and was medicated initially with Seroquel 100mg po and then subsequently with Ativan 2mg IM. Patient has legal hx and was in prison 5/2007 to 3/2008 on Assault 2nd conviction and completed PRS on 3/19/11.

INPATIENT REASSESSMENT 4/18/12: Mr. Terrance Hale is a 26-year-old, domiciled with mother, African American man who is unemployed and on SSI according to records,

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19N-14-B	Hale,Terrance	3501306	3501306-1	27Y	M

Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Chief Complaint : "You know why I am here...so why do I have to answer these questions.".

History of Present Illness (WP): ON ADMISSION 4/17/12: Patient is a 26yo man who is unemployed, on SSI, who lives with mother, who has a girlfriend who is the mother of his two children who are 6yo and 3yo, who has a h/o psychiatric hospitalizations including state, who was last hospitalized about a year ago at MSMC and currently in out-patient treatment at St. Mark's Clinic (although was last seen there about one month ago) and who is on Latuda 40mg QD (was previously on 80mg/d) and who was reffered for forensic admission evaluation from MHC CPEP. Patient is under arrest and has been charged with allegedly stabbing one of the officers who responded to mother's 911 call to have patient brought to hospital as EDP. Patient is very sullen and states that he does not want to answer any questions but with encouragement, he did answer some. Mother also called the CPEP before patient was seen and provided the following information. Mother stated that the patient has been more withdrawn and irritable and had been pacing a lot and that he asked her to call the ambulance for him so that he could go to hospital. Mother states that she waited downstairs for the police and ambulance and that it took almost a half hour for the ambulance to arrive. Mother stated that as the police were about to head to the apartment, the patient exited the elevator and that police approached hi, and reportedly were escorting him to the ambulance when it is alleged that the patient stabbed and cut one of the officers. Mother states that he used to be on Prolixin, Cogentin and Depakote but was c/o N/V (most likely the VPA) and was taken off

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DIS-19N-14-B	Hale,Terrance	3501306	3501306-1	27Y	M

Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

previous prescription. Mrs. Hale stated that Mr. Hale was "fine" and "happy" until around Easter approximately 2 weeks ago. She explained that he was "withdrawn," "sad," and "not sleeping." She explained that he would take 4-5 hour "catnaps" each day, and that she would give him leftover Trazodone that he was prescribed at one time. She stated that she first noticed that he needed mental health treatment when Mr. Hale was 16/17, and that he was "arguing, acting out, angry, and thought that people were after him." She also described him as cutting himself off from friends around this time. Mrs. Hale reported that Mr. Hale carries a diagnosis of "bipolar schizophrenia," and that her brother has "the same thing." She further provided that Mr. Hale was first hospitalized at around 16/17 at Mount Sinai MC, and that he has had 5 or 6 subsequent hospitalizations, including one at Rockland Psychiatric Center. When questioned about the incidents that prompted these hospitalizations, Mrs. Hale described agitated, aggressive, and paranoid behavior. She also stated that Mr. Hale has become violent while in psychiatric hospitals. Mrs. Hale stated that the patient has been arrested multiple times, probably for the first time around 2002, typically for "fighting." She stated that he has never been sentenced/mandated to any kind of treatment program, and has never received AOT.

According to Dr. Nunes at St. Mark's Clinic, Mr. Hale was seen approximately 3 weeks ago for one psychiatric evaluation. He has previously "quit" outpatient treatment there in the past, prior to the clinic using a

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Unscheduled Discharge Summary-Psych IP -- cont'd

system of computerized records. During her evaluation 3 weeks ago, Dr. Nunes described the patient as carrying a diagnosis of schizophrenia, but presently denying all symptoms of psychiatric illness. According to Dr. Nunes, Mr. Hale reported that he would like medication in order to prevent him from becoming ill again in the future. Though he had been prescribed Haldol and Depakote in the past, Mr. Hale reportedly told Dr. Nunes that he did not like these medications. Dr. Nunes stated that she prescribed Latuda 40mg, and that Mr. Hale agreed to take it.

Prior Mental Health Srvcs : Outpatient mental health provider,Psychiatric inpatient unit,State psychiatric hospital

AOT Status : no aot involvement

High Risk Psychiatric Hx : Violence or endangering others,Arrest or incarceration,Treatment noncompliance

Psychopharm History : Drug Name: prolixin Dosage and Compliance: 5mg bid
Drug Name: latuda Dosage and Compliance: up to 80mg daily
Drug Name: depakote
Drug Name: cogentin

Past Psychiatric History (WP): As per admission note the patient has diagnosis of schizophrenia, paranoid type and he is enrolled at St Mark's clinic where his psychiatrist is Dr. Nunez, MD Tel. (212) 982-3470; he was an inpatient at Mt Sinai Medical Center one year ago and he was in "the State Hospital" in the past. More exploration needed; patient refused treatment team initial assessment interview. Patient denied audiovisual hallucinations or suicide or homicide thoughts. He did not appeared psychotic during this short assessment interview.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Substances of Abuse : Cannabis (Marijuana) still using First: unk Last: days-wks before admission [utox pos for THC]
Complicated Withdrawal : Unable to assess
Effects of Substance Use : Unable to assess
Abuse History : unable to assess
Current Effects of Abuse: Unable to assess
Developmental Hx (WP) : Patient left treatment team initial assessment interview unexpectedly. More exploration needed. As per admission note the patient grew up without a father; he is single and has two children ages 4 and 3 (patient said their ages are 3 and 5 years and that they are girls) living with patient's mother and girlfriend. Patient eloped from school from 9th grade and he was in special education. The patient is in SSI.
Family History Categories: Other psychiatric illness
Version : retention documentation
Residence Selection : adult
ACS/APS Involvement : unable to assess
Historical Risk Factors: Suicide Hx: Impulsive or reckless behavior,Major mental illness or personality disorder
Violence Hx: History of violence,Psychiatric hospitalizations,Recent violence,Violence during prior psychiatric inpatient treatment
Suicide Risk Mitigation: Social network, supports, or treatment,Unable to assess
Current Risk Factors : Suicide Cr: Social isolation Violence Cr: Hostile
Self-Care: None of the indicators of poor self-care

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Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

Admission Date : Tue, 17 Apr 2012

Admitting Diagnosis : Paranoid type schizophrenia, chronic (295.32)

Hospital Course (WP): During his hospital stay, Mr. Hale was observed to be irritable, guarded, isolative, and uncooperative. He once received IM medication (Ativan 2mg and Prolixin 5mg) for agitated, threatening behavior in the early morning hours of 4/18/12, while in CPEP. Though he agreed to be interviewed later that morning, Mr. Hale refused to answer most of the team's questions, and after a short time left the interview. He denied all psychiatric symptoms, and provided consent for the treatment team to contact his mother and a psychiatrist he had recently seen for an evaluation at St. Mark's Clinic [please see HPI as well as attending note on 4/19 for info obtained from St. Mark's clinic]. Mr. Hale continued to present as isolative, but was not observed to engage in any self-injurious or assaultive behaviors. He was able to follow staff directions, and was compliant with medication. No overt symptoms of psychosis were observed. Patient's thought process was coherent and goal directed throughout his admission and he voices wish to be discharged to arraignment in a logical and rational manner. Patient remained in good behavioral control while on 19N. He ate at meals and slept at night. He was compliant with medication.

He will be discharged to NYPD custody - medication on discharge is prolixin 5mg bid.

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Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

Appearance	: Appears stated age,Adequately dressed
Behavior	: Hostile,Indifferent,Avoidant eye-contact
Speech	: Normal rate,Normal volume
Thought Process	: Goal directed
Thought Content	: Normal content
Suicidal Ideation	: No suicidal ideation
Aggressive Ideation	: No aggressive or homicidal ideation
Perceptual Disorders	: No perceptual disorders
Mood	: Irritable
Affect	: Constricted
Impulse Control	: Intact impulse control
Cognitive Function	: Alert
Insight	: Impaired insight
Judgment	: No grossly impaired judgment

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Unscheduled Discharge Summary-Psych IP -- cont'd

Formulation (WP) : Mr. Terrance Hale is a 26-year-old, domiciled with mother, African American man who is unemployed and on SSI according to records, and unmarried with two children (ages 3 and 5 according to patient). He has a history of 5 or 6 psychiatric hospitalizations including one state hospitalization since the age of 16/17, a history of a recent outpatient psychiatric evaluation at St. Mark's Clinic, and a history of multiple arrests for violent behavior, which led to one state prison incarceration from 5/2007 - 3/2008 (charges of Assault). His substance use history is presently unknown. The patient was arrested on or about 4/17/12; according to records Mr. Hale's mother called 911 seeking hospitalization for Mr. Hale, and when police arrived Mr. Hale is alleged to have stabbed a police officer in the temple, causing a severe, penetrating injury requiring surgery. Mr. Hale was taken to Metropolitan Hospital Center (MHC), where he was observed to be internally preoccupied, and referred for forensic psychiatric admission at BHC on pre-arraignment status. At BHC CPEP, Mr. Hale presented as sullen and irritable. While in CPEP Mr. Hale initially refused to answer any questions, but eventually stated that he has a past diagnosis of paranoid schizophrenia, though he does not believe he suffers from a mental illness. He denied all symptoms of mental illness, including depressed mood, AH/VH/SI/HI, and no delusions were elicited. He provided that he asked his mother to call the ambulance because he has not been able to sleep for several days and was feeling exhausted. Also while in CPEP, Mr. Hale became agitated and received Seroquel 100mg po, and later Ativan 2mg IM. The patient was admitted to 19N, and there were no incidents overnight.

On inpatient reassessment the morning of 4/18/12, Mr. Hale's thought process was coherent and goal-directed. He presented as irritable and uncooperative, and with no overt signs of psychosis.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Mr. Hale denied all symptoms of mental illness, including AH/VH/SI/HI, and depressed mood. He did provide that he has been "tired," and had not been sleeping well recently. Mr. Hale provided verbal consent for the treatment team to contact his mother and a psychiatrist he had recently seen for an evaluation at St. Mark's Clinic. The team was unable to conduct a complete and thorough interview and assessment of Mr. Hale, as he became irritable and left the room.

During his hospital stay, Mr. Hale was observed to be irritable, isolative, and uncooperative. He was not observed to engage in any self-injurious or assaultive behaviors. He was able to follow staff directions, and was compliant with medication.

Past records as well as collateral contact indicate a history of psychotic illness (paranoid schizophrenia/schizoaffective disorder), as well as aggressive, agitated behavior and paranoia. However, during his brief hospitalization Mr. Hale was not observed to demonstrate any overt symptoms of psychosis, thought disorder, or any other Axis I illness. He continued to be guarded, isolative, and uncooperative with the treatment team. Further, BHC CPEP clinicians assigned an Axis II diagnosis of Antisocial PD which is consistent with Mr. Hale's irritable and uncooperative presentation upon inpatient interview; this diagnosis should be considered as a differential. Pending his cooperation, a thorough diagnostic evaluation and continued risk assessment is warranted at a future date and time. At this time, patient is verbalizing wish to be discharged to arraignment in a coherent and goal-directed manner and is not observed to be endorsing acute psychiatric symptoms.

Patient's irritability and refusal to cooperate with the treatment team upon interview precluded a full

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Unscheduled Discharge Summary-Psych IP -- cont'd

and thorough risk assessment. The following is based on the information presently available, and further assessment is required. Regarding risk of harm to self, Mr. Hale is presently at low to moderate risk. He denies suicidal ideation and depressed mood, has no known history of SI, self-injurious behaviors, or suicide attempts (as per mother), and does not appear to be withdrawing from substances or suffering from untreated pain. Regarding risk of harm to others, Mr. Hale is felt to be at high risk, and chronically so. Although he currently denies aggressive/homicidal ideation, the patient has a history of previous violence beginning at a young age and including violence while hospitalized (as per mother), has been diagnosed with a psychotic illness in the past, may have a personality disorder, lacks insight into his illness, has recently been impulsive with low frustration tolerance, has a history of arrests/incarcerations and treatment non-compliance. Patient is currently mildly irritable and hostile, although calm. He has refused to answer most questions to treatment team. Also according to the patient's mother, he has a history of paranoid thinking.

Plan:
-Patient currently calm, with no overt/acute symptoms of psychosis, not thought disorder, and voicing wish to be discharged to arraignment in a logical and rational manner. Discharge patient to arraignment.
-Continue psychiatric medications - Prolixin 5mg bid - patient's mother reports that he has a history of diabetes, but he denied this; routine medical monitoring.

Axis I : Unspecified psychosis
Axis II : Diagnosis Deferred on Axis II
Axis III : Routine general medical examination at a health care facility
Axis IV : Problems related to interaction with the legal system/crime

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Unscheduled Discharge Summary-Psych IP -- cont'd

Axis V : current 55
Discharge Diagnosis : Unspecified psychosis
Housing Type : Correctional
Housing Specific : NYPD
Aftercare Type : Follow-up Onsite
Aftercare Specific : Riker's MHC, pt very likely to be housed at Rikers after arraignment
Pt Agrees with Dispo : patient agrees with disposition
Family/Oth Invlvd in Dispo: family/other involved in disposition
Family/Oth Invlvd Contact : Patient's mother: Vearry Hale Tel. (917) 309-4085 and (212) 426-2123
Discharge Documentation : now
Multiple Antipsychotics : One antipsychotic agent
Attending Discharge Signature : i have reviewed and agree with the discharge summary

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DIS-19N-14-A	Hale,Terrance	3501306	3501306-2	27Y	M

Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP
Event Time: Mon, 30 Apr 12 1009 Status: corrected

Mon, 30 Apr 12 1428 Documented by Loren Roth, MD

Start Time of IP Assmnt: 23 Apr 12 1015
Source of Referral : Jail, lockup, penetentiary, or DOC-state
Sources of Information : Patient,Facility computerized records,Referral letter
Barriers to Assessment : Psychosis or confusion
Consenting Party : patient consents or involuntary treatment
Preferred Language(s): English

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Unscheduled Discharge Summary-Psych IP -- cont'd

Chief Complaint : Evaluation of symptoms of psychosis

History of Present Illness (WP): The patient is a 26-year-old African American male, previously domiciled with his mother, unemployed on SSI, unmarried with two children (ages 3 and 5), currently incarcerated at Rikers for allegedly stabbing an NYPD officer in the head after NYPD responded to a 911 call from his mother, with a reported history of a diagnosis of schizophrenia, paranoid type, multiple past hospitalizations including state hospitalization, a known history of multiple arrests for violent behaviors, recently discharged from 19 N on 4/20, PMH of DMII, who was referred from Rikers today for psychiatric evaluation in the context of reported symptoms of psychosis. As per his referral letter from Rikers, since his return the patient has demonstrated prominent thought blocking, distractibility, and paranoia, as well as homicidal ideation with no plan. Prior to his transfer from Rikers today, additional collateral was also obtained from Rikers psychiatrist, Dr. Simpson, who informed Bellevue staff that the patient expressed paranoid ideation that the COs wanted to harm him.

On interview the patient was noted to demonstrate an inappropriately flattened affect, with a paucity of speech, and what appeared to be thought blocking. He also appeared somewhat internally preoccupied at times, with periods where he appeared to lose focus on the conversation, requiring that questions be asked multiple times. He reports that since he has returned to Rikers he has been compliant with the Prolixin that was started at Bellevue, and denies having any difficulty or safety concerns with

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Unscheduled Discharge Summary-Psych IP -- cont'd

either other inmates or with DCC staff. He denies current or recent AH, VH, IOR, symptoms of mania or depression. He also denies SI and HI, with no reported thoughts to harm himself or others. He reports that he has difficulty sleeping at night, sleeping only several hours a night. With regard to his medications he reports that he feels that they historically have been helpful for keeping him "relaxed".

Inpatient reassessment:
Pt is known to me from his 2 day admission on 19N last week. Today he appeared more oddly related than last week, when he had appeared apathetic. Today he demonstrated odd/inappropriate smiling - "I feel good!" he said with a grin, which is inappropriate to the current situation. He confirmed that he needs to be on meds and that they help him, although 'I can't say what the meds do...' He asked for clothes, lamenting the fact that he has no underwear and making plans to have his mother bring clothes. I asked about his hx of DM; he said little about it, but did answer 'no' when I asked if he'd had medical admissions in the past for DM.

Pt was given psychoed on safe behavior on the unit. He is aware of his next court date, 5/17.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Prior Mental Health Srvcs : Outpatient mental health provider,Psychiatric inpatient unit,State psychiatric hospital

AOT Status : no aot involvement

High Risk Psychiatric Hx : Violence or endangering others,Arrest or incarceration,Treatment noncompliance

Psychopharm History : Drug Name: prolixin Dosage and Compliance: 5mg bid
Drug Name: latuda Dosage and Compliance: up to 80mg daily
Drug Name: depakote
Drug Name: cogentin

Past Psychiatric History (WP): As per chart review from 4/17 admission to 19 N - Collateral from the patient's mother, Mrs Hale:

"She stated that she first noticed that he needed mental health treatment when Mr. Hale was 16/17, and that he was "arguing, acting out, angry, and thought that people were after him." She also described him as cutting himself off from friends around this time. Mrs. Hale reported that Mr. Hale carries a diagnosis of "bipolar schizophrenia," and that her brother has "the same thing." She further provided that Mr. Hale was first hospitalized at around 16/17 at Mount Sinai MC, and that he has had 5 or 6 subsequent hospitalizations, including one at Rockland Psychiatric Center. When questioned about the incidents that prompted these hospitalizations, Mrs. Hale described agitated, aggressive, and paranoid behavior. She also stated that Mr. Hale has become violent while in psychiatric hospitals. Mrs. Hale stated that the patient has been arrested multiple times, probably for the first time around 2002, typically for "fighting." She stated that he has never been sentenced/mandated to any kind of treatment program, and has never received AOT"

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Unscheduled Discharge Summary-Psych IP -- cont'd

With regard to his recent symptoms that led to his hospitalization on 4/17:

"Mrs. Hale explained that Mr. Hale has a history of psychiatric medications that includes Thorazine, Depakote, and a medication to combat "shaking," and he has presently been taking Latuda 80mg. He had recently been prescribed Latuda 40mg by Dr. Nunes at the St. Mark's Clinic, but Mrs. Hale felt that this was not adequate, and began giving her son the medication of a stronger dosage that was left over from a previous prescription. Mrs. Hale stated that Mr. Hale was "fine" and "happy" until around Easter approximately 2 weeks ago. She explained that he was "withdrawn," "sad," and "not sleeping." She explained that he would take 4-5 hour "catnaps" each day, and that she would give him leftover Trazodone that he was prescribed at one time"

Patient was previously followed by Dr. Nunes at St. Mark's Clinic, for outpatient treatment, where he was diagnosed with schizophrenia. Past medication trials have included Prolixin, Cogentin, Depakote, Thorazine, Haldol, and Latuda.

While hospitalized on 19N, Mr. Hale was reportedly irritable, guarded, isolative and uncooperative. No dangerous behaviors were observed, nor were any overt symptoms of psychosis. Prolixin 5 mg twice daily was restarted which the patient was compliant with.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Substances of Abuse : Cannabis (Marijuana) still using First: unk
Last: days-wks before admission [utox pos for THC]
Alcohol (Ethanol, etc.) still using

Complicated Withdrawal : Unable to assess

Effects of Substance Use : Unable to assess

Chemical Abuse History (WP): Patisnt reports that he formerly snoked cannabis several times a week, and routinely consumed etoh on weekends.

Abuse History : unable to assess

Current Effects of Abuse: Unable to assess

Developmental Hx (WP) : As per chart review

"As per admission note the patient grew up without a father; he is single and has two children ages 4 and 3 (patient said their ages are 3 and 5 years and that they are girls) living with patient's mother and girlfriend. Patient eloped from school from 9th grade and he was in special education. The patient is in SSI."

Family History Categories: Unable to assess

Version : retention documentation

Residence Selection : adult

ACS/APS Involvement : unable to assess

Historical Risk Factors: Suicide Hx: Recent discharge from psychiatric admission,Imuplsive or reckless behavior
Violence Hx: History of arrest, DWI, or moving violations,History of violence
Suicide Risk Mitigation: Social network, supports, or treatment

Current Risk Factors : Suicide Cr: Social isolation Violence Cr: Hostile
Self-Care: None of the indicators of poor self-care

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Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

Admission Date : Sat, 21 Apr 2012

Admitting Diagnosis : Paranoid type schizophrenia, chronic (295.32)

Hospital Course (WP): Pt was admitted on a Saturday, approximately 24 hrs after having left 19N for arraignment. On reassessment with MD on 19N on Monday April 23rd, the pt had an affect that was more inappropriate than what had been observed before. He was laughing inappropriately. However, he was generally goal directed in TP and was not agitated. He remained irritable and not engaged with treatment team, that day and throughout this admission, as he had been here the week before.

The inappropriate affect was not observed after Monday 4/23. In fact, there were no other psychotic sx or other sx of major mental illness observed in the remainder of this admission. The pt was generally isolative and spent a lot of time in bed. He did not attend grps although did go to the rec room a couple times. He was compliant with medication. He got IM medication on 2 occasions, both of which were felt to be incidents related to poor frustration tolerance and poor impulse control, not to psychosis or mania. On one occasion, it was related to phone use, and on another occasion, it was related to pt's frustration that his tray came up from the kitchen late. In the latter incident, he was threatening and threw his tray on the floor.

The pt did not require 1;1 observation at any time. He was generally irritable with MD [but did not lose behavioral control] and showed disinterest in treatment. He confirmed that medication helped him stay calm but did not report any specific sx or ask for help with any other problems. On one occasion, he asked to see MD with MHLS. Pt expressed a wish to leave Bellevue and return to Rikers, although he also expressed superficial willingness to comply with tx plan in the hospital in the meantime, until discharge occurs.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Pt and/or his mother had reported a hx of DM, but lab work showed normal A1C [5.3%] and normal fasting glucose. Lft's were mildly elevated. GGT was elevated on admission at 99.

Pt's mother was very involved in her son's admission, making frequent calls to treatment team members and MHLS. She was concerned that the pt was not getting adequate food [on a high cal diet] and that his visiting hours were different than other pts [she reportedly spoke to a DOC captain about this]. She reported that he had eczema and needed treatment, but the pt denied having problems with this and did not want treatment for any skin issues. She expressed concern that the pt was dehydrated; his pulse is mildly elevated in the 90s to 101, but his BUN/creat are normal as of day of discharge. He eats at meals and does not appear medically ill or medically decompensated.

In summary, pt was not noted to have any psychotic sx during this admission. He did not show poor self care, disorg'n, internal preoccupation, mania, or self injurious behavior. Pt has expressed a wish to leave the hospital and is not felt be meet criteria for involuntary commitment at this time.

Pt will be discharged on
Prolixin 5mg BID
Depakote 500mg q-am and 1000mg at bedtime - depakote level was 91.7 on day of discharge
Klonopin 1mg TID
Trazodone 100mg daily
Cogentin 1mg at bedtime
Please follow LFTs as they are mildly elevated [55 and 67] on day of discharge

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Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

Appearance	: Appears stated age,Adequately dressed
Behavior	: Hostile,Indifferent,Avoidant eye-contact
Speech	: Normal rate,Soft
Thought Process	: Goal directed
Thought Content	: Normal content
Suicidal Ideation	: No suicidal ideation
Aggressive Ideation	: No aggressive or homicidal ideation
Perceptual Disorders	: No perceptual disorders
Mood	: Irritable
Affect	: Constricted,Stable affect
Impulse Control	: Intact impulse control
Cognitive Function	: Alert
Insight	: No grossly impaired insight
Judgment	: Impaired judgment

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Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

Formulation (WP) : 26 yo single AAM, father of 2 girls, who was domiciled with his mother, on SSI with hx of psych illness and mult prior hospns, hx of arrest and prison time in the past for assault, arrested for multiple felonies stemming from an incident with the police in which the pt allegedly stabbed a police officer. The pt was on 19N as a pre-arraignment prisoner, arraigned, went to Rikers and then referred back to Bellevue on 4/21 because of concerns about psychotic sx.

On readmission interview with 19N MD on 4/23, pt was more oddly related than the prior week, with inappropriate smiling. He did not give much history. After the interview he showed poor impulse control and lunged at another pt. In the remainder of the hospitalization, pt did not show any grossly inappropriate behavior or sx. He did not appear disorg'd, internally preoccupied, manic, depressed, or unable to care for himself. He did appear irritable and disinterested in treatment. He expressed a wish to leave the hospital.

Risk of harm to others is felt to be chronically moderate to high. Pt has hx of violence and arrest, with unpredictable behavior during this admission [2 doses of IM medication] and little communication with tx team. However, pt has been compliant with medication and pt has not actually been violent during this admission. Pt denies plans to hurt self and has not had recent self injurious behavior; risk of harm to self is considered low to moderate. Pt has social isolation and psych illness, both of which raise his overall risk. Pt has a supportive mother who is quite involved in his care here.

Diagnosis by hx [and according to what was observed at Rikers and by admitting MD in CPES] is a psychotic d/o, although collateral info obtained from a prior provider [during last admission 4/18-4/20] was not

Bellevue Hospital CenterBellevue Hospital CenterBellevue Hospital CenterBellevue
Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19N-14-A	Hale,Terrance	3501306	3501306-2	27Y	M

Attending Physician	D.O.B.
Roth,Loren	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

illustrative regarding why pt has dx of psychotic d/o and why he has been hosp'd in the past. Poor impulse control does seem to be a component of pt's presentation, both past and present.

Please see discharge medication list in Hosp Course section.

Axis I : Paranoid type schizophrenia, chronic
Axis II : Diagnosis Deferred on Axis II
Axis III : Routine general medical examination at a health care facility
Axis IV : Problems related to interaction with the legal system/crime,Problems with access to health care services
Axis V : current 40
Discharge Diagnosis : Unspecified psychosis
Housing Type : Correctional
Housing Specific : Rikers AMKC
Aftercare Type : Follow-up Onsite
Pt Agrees with Dispo : patient agrees with disposition
Family/Oth Invlvd in Dispo: family/other involved in disposition
Family/Oth Invlvd Contact : pt's mother Ms. Hale 917 309 4085
Discharge Documentation : later
Attending Discharge Signature : i have reviewed and agree with the discharge summary

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP
Event Time: Mon, 02 Jul 12 1348 Status: complete

Mon, 02 Jul 12 1350 Documented by Steven Konrad, MD

Start Time of IP Assmnt: 20 Jun 12 1030
Source of Referral : Jail, lockup, penetentiary, or DOC-state
Sources of Information : Patient,Facility computerized records,Referral letter
Barriers to Assessment : None
Consenting Party : patient consents or involuntary treatment
Preferred Language(s): English

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician: Konrad,Steven
D.O.B.: 02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Chief Complaint : "I'm feeling sick mentally"

History of Present Illness (WP): ON ADMISSION 6/19/12:
26 yo AAM with reported hx of schizophrenia and prior inpat treatment, arrested in april 2012 for alleged attempted murder of an officer [stabbing] who was called to his home by him and/or his mother, admitted in April while under NYPD custody to 19N, referred back to Bellevue because of concerns about agitation and lability. The pt was treated for a few days on 19N after the arrest, then was discharged to arraignment, then was returned to Bellevue approx 24 hrs later for agitation. He was readmitted to 19N where he remained for 9 days. During that time he had 2 doses of IM medication for behavior which was felt to be related to poor impulse control but not necessarily psychosis. Pt was noted at times to be oddly related and laughing to himself. He was eventually discharged on april 30 at his own request when he had shown calm behavior. He has been at Rikers since then. Meds at Rikers are currently Prolixin 5mg bid, buspar 5mg bid, Cogentin 1mg bid, Depakote 500mg qam and 1000mg at bedtime, Trazodone 100mg at bedtime. On this interview, pt is very quiet and stern, answering questions coherently and in a terse manner with poor eye contact. He admits upon questioning that he became 'upset' after a conversation 'with my family' - clarification reveals that he is in fact referring to his mother, with whom it seems he has a complicated relationship [she frequently called 19N last time and also reportedly calls doctors at Rikers in the recent past]. Pt would not elaborate on how he acted when he was 'upset', but referral indicates that 'he has been

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

extremely labile, ... they had to lock down his cell area due to an angry outburst where he threatened all the other patients in his housing area.' Asked if felt that his being 'upset' was related to his illness [he endorses having an illness], he said no, he thought it was about losing his temper. He confirms that he does, in fact, want help in being on medication that will help him control his temper. Of note, he feels he should not be 'blamed' for his temper, as 'it's the doctor's fault for not putting me on the right medication.' Pt denies SI, HI and AVH, although he does report that, at times, he wonders if perhaps he should not be alive. His next court date is July 11 and he appears apathetic about that, as though he has some hopelessness about the situation. He reports his sleep has been difficult and he has not been eating well [reason: he has been moved from one housing area to another recently, and he states that when that happens, other inmates tend to take your food when you're new to the housing area]. Pt signed in 9.13 and agreed to get labwork and ekg done.

INPATIENT REASSESSMENT 6/20/12:
Since arriving on 19W last night, Mr. Hale has been calm and quiet, noted to be somewhat affectively flat. On interview with his primary team this morning, he was much the same as on admission. He was terse, irritable, guarded, required significant encouragement to elaborate on his responses, nevertheless was coherent, logical, goal-directed. The content of his statements was mainly remarkable for externalization and an oppositional stance. He said he was hospitalized because he is

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

"feeling sick mentally" and when asked what he was experiencing said it was "just thoughts... I'm upset, depressed, stressed." When asked what had been upsetting him, he explained that things were not going well for him at Rikers because "they keep moving me, like they want to piss me off or something. Why can't they just leave me alone?" However, when pressed, he admitted that he had been moved to a cell recently, which he prefers over the dorm setting, then could not explain why he was so upset about being moved if he likes where he was moved to. He also complained that he had not been told what medications he was prescribed. He made vague statements about feeling that his medications are not working, but could not explain what symptoms in particular he feels could be better treated. When confronted with information from the referral letter indicating he had been labile and threatening at Rikers, he denied this and asserted "they're lying... they're always lying on me" and went on to speak about the ways in which "they" were trying to provoke him at Rikers "to make me catch a new charge." He denied thoughts of self-harm or violence, denied current hallucinations, did not voice any frankly delusional material, however as the interview progressed he began to make statements about people hating him and wanting to kill him (however, this may be reality based as the nature of his charge places him at risk of being targeted by other inmates and possibly DOC staff at Rikers, and he is in fact on a DOC 1:1 presumably for this reason), and about being like Jesus Christ (but not being Jesus Christ himself) and dying for his family.

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

He specifically stated that he would never kill himself, but that "I'm just waiting for someone to do it for me." Other than paranoid-sounding statements and a guarded stance that may or may not reflect underlying paranoia, there were no clear objective indicators of acute mania, neurovegetative depression, or active psychosis, and on the basis of this initial interaction with the patient he appeared capable of controlling his behavior when motivated to do so. He did not spontaneously mention his legal situation or his family as stressors, did not mention a stressful phone call with his mother, and refused to discuss his feelings about those issues when asked. While he did agree that he wants to be in the hospital "for help," he could not explain what kind of help he would like.

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Prior Mental Health Srvcs : Outpatient mental health provider,Psychiatric inpatient unit,State psychiatric hospital

AOT Status : no aot involvement

High Risk Psychiatric Hx : Violence or endangering others,Arrest or incarceration,Treatment noncompliance

Psychopharm History : Drug Name: prolixin Dosage and Compliance: 5mg bid
Drug Name: latuda Dosage and Compliance: up to 80mg daily
Drug Name: depakote
Drug Name: cogentin

Past Psychiatric History (WP): As per chart review from 4/17 admission to 19 N - Collateral from the patient's mother, Mrs Hale:

"She stated that she first noticed that he needed mental health treatment when Mr. Hale was 16/17, and that he was "arguing, acting out, angry, and thought that people were after him." She also described him as cutting himself off from friends around this time. Mrs. Hale reported that Mr. Hale carries a diagnosis of "bipolar schizophrenia," and that her brother has "the same thing." She further provided that Mr. Hale was first hospitalized at around 16/17 at Mount Sinai MC, and that he has had 5 or 6 subsequent hospitalizations, including one at Rockland Psychiatric Center. When questioned about the incidents that prompted these hospitalizations, Mrs. Hale described agitated, aggressive, and paranoid behavior. She also stated that Mr. Hale has become violent while in psychiatric hospitals. Mrs. Hale stated that the patient has been arrested multiple times, probably for the first time around 2002, typically for "fighting." She stated that he has never been sentenced/mandated to any kind of treatment program, and has never received AOT"

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
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Unscheduled Discharge Summary-Psych IP -- cont'd

With regard to his recent symptoms that led to his hospitalization on 4/17:

"Mrs. Hale explained that Mr. Hale has a history of psychiatric medications that includes Thorazine, Depakote, and a medication to combat "shaking," and he has presently been taking Latuda 80mg. He had recently been prescribed Latuda 40mg by Dr. Nunes at the St. Mark's Clinic, but Mrs. Hale felt that this was not adequate, and began giving her son the medication of a stronger dosage that was left over from a previous prescription. Mrs. Hale stated that Mr. Hale was "fine" and "happy" until around Easter approximately 2 weeks ago. She explained that he was "withdrawn," "sad," and "not sleeping." She explained that he would take 4-5 hour "catnaps" each day, and that she would give him leftover Trazodone that he was prescribed at one time"

Patient was previously followed by Dr. Nunes at St. Mark's Clinic, for outpatient treatment, where he was diagnosed with schizophrenia. Past medication trials have included Prolixin, Cogentin, Depakote, Thorazine, Haldol, and Latuda.

While hospitalized on 19N, Mr. Hale was reportedly irritable, guarded, isolative and uncooperative. No dangerous behaviors were observed, nor were any overt symptoms of psychosis. Prolixin 5 mg twice daily was restarted which the patient was compliant with.

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician: Konrad,Steven
D.O.B.: 02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Substances of Abuse : Cannabis (Marijuana) still using First: unk Last: days-wks before admission [utox pos for THC]
Alcchol (Ethanol, etc.) still using

Complicated Withdrawal : Unable to assess
Effects of Substance Use : Unable to assess
Chemical Abuse History (WP): Patient reports that he formerly smoked cannabis several times a week, and routinely consumed etoh on weekends.

Abuse History : unable to assess
Current Effects of Abuse: Unable to assess
Developmental Hx (WP) : As per chart review

"As per admission note the patient grew up without a father; he is single and has two children ages 4 and 3 (patient said their ages are 3 and 5 years and that they are girls) living with patient's mother and girlfriend. Patient eloped from school from 9th grade and he was in special education. The patient is in SSI."

Family History Categories: Unable to assess
Version : retention documentation
Residence Selection : adult
ACS/APS Involvement : unable to assess
Historical Risk Factors: Suicide Hx: Chemical abuse or dependency (current or past),Impulsive or reckless behavior,Major mental illness or personality disorder,Past suicidal ideation,Relationship instability Violence Hx: Chemical abuse or dependency,History of arrest, DWI, or moving violations,History of violence,Psychiatric hospitalizations,Unemployment or repeated job losses,Violence during prior psychiatric inpatient treatment Suicide Risk Mitigation: Reality testing ability

Current Risk Factors : Suicide Cr: None of the listed suicide risk factors Violence Cr: None of the listed violence risk factors

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DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Admission Date : Tue, 19 Jun 2012

Admitting Diagnosis : Adjustment disorder with mixed disturbance of emotions and conduct (309.4)

Hospital Course (WP): Mr. Hale was referred from Rikers on 6/19/12 due to concerns about agitation, lability, and threatening behavior at AMKC. On admission evaluation he was logical and coherent but terse. He admitted to "losing his temper" due to what he described as repeated housing changes at Rikers, and expressed wanting to be on medications that better controlled his temper. He appeared apathetic about his court case and voiced eating and sleeping disturbances, also related to housing changes at Rikers. He denied thoughts of self-harm or violence, denied hallucinations. He agreed to voluntary admission to 19W. His medications at Rikers were listed as Prolixin 5mg bid, Buspar 5mg bid, Cogentin 1mg bid, Depakote 500mg qam and 1000mg at bedtime, trazodone 100mg at bedtime, and these were restarted on admission. He has been accepting these medications.

On inpatient reassessment on 6/20/12, Mr. Hale was terse, irritable, guarded, required significant encouragement to elaborate on his responses, nevertheless was coherent, logical, goal-directed. The content of his statements was mainly remarkable for externalization and an oppositional stance. He again denied thoughts of self-harm or violence, denied current hallucinations, and did not voice any frankly delusional material, however as the interview progressed he began to make statements about people hating him and wanting to kill him, about DOC and other inmates trying to provoke him, and about being like Jesus Christ (but not being Jesus Christ himself) and dying for his family. He specifically stated that he would never kill himself, but that "I'm just waiting for someone to do it for me." Other than these paranoid-sounding statements and his guarded stance, there were no clear objective indicators of acute mania, psychosis, or neurovegetative depression. He

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

voiced feeling "sick mentally" and wanting his medications to be adjusted to better target his symptoms, but had difficulty elaborating on what he specifically wanted help with.

On the afternoon of 6/21/12, Mr. Hale stated he felt like "punching someone in the face," but was calm after receiving prn medications. On 6/22/12, he was observed by staff pacing angrily in the hallway, pushing past and throwing elbows at peers and staff, and had an angry confrontation with a disorganized peer. Staff who intervened and spoke with him reported that he felt that the hospital staff were in league with DOC staff in trying to provoke him. He expressed feeling frustrated about being in the hospital and about his legal situation, and wanting to return to Rikers for more food and greater freedom of movement, but agreed to stay for further treatment. He continued to appear tense over the weekend but was less irritable and more verbal with peers and staff, and was able to request prn medication on Sunday. On 6/25/12, he was able to tolerate a long discussion with his primary therapist about the reasons for his repeated presentations to Bellevue and about continuing his stay in order to work on how to cope with his situation at Rikers given the nature of his legal case, and he said he would consider this. He was oddly related, with an odd smile, but not overtly psychotic, manic, or depressed.

During his second week of admission, Mr. Hale was minimally engaged with staff. When approached, he responded tersely to questions, generally denied any complaints, at times spoke about feelings of frustration around his incarceration and legal situation but declined to meet for psychotherapy sessions to address his coping skills, and frequently asked to be left alone. He was noted to enjoy recreational groups, but did not attend any therapeutic groups despite encouragement. At times he was more irritable, but at other times he was observed with an

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale, Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad, Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

odd smile. He continued to be free of any overt signs of psychosis, mania, or depression. He accepted his standing medications and requested prn medications infrequently. There were no behavioral incidents, and he was able to calmly relate to his treatment team that he wished to return to Rikers so that he could have greater freedom of movement and because he felt that would help him move forward with his legal case. By 7/1/12 Mr. Hale was assessed to be stable for stepdown to outpatient management at Rikers Island, and was discharged to AMKC.

Medications on discharge:
Depakote 500mg am/1000mg pm (VPA level on 6/26 = 129)
Prolixin 5mg twice daily
Buspar 7.5mg twice daily
Cogentin 1mg twice daily
trazodone 150mg at bedtime

Appearance	: Appears stated age, Adequately dressed, Adequate grooming
Behavior	: Cooperative, Normal eye-contact, Normal psychomotor activity, No abnormal movements, Normal gait
Speech	: Normal rate, Normal volume, Normal rhythm, Fluent, Non-pressured, Standard English accent
Thought Process	: Goal directed, Concrete thinking
Thought Content	: Normal content
Suicidal Ideation	: No suicidal ideation
Aggressive Ideation	: No aggressive or homicidal ideation
Perceptual Disorders	: No perceptual disorders
Mood	: Euthymic
Affect	: Constricted, Stable affect
Impulse Control	: Intact impulse control
Cognitive Function	: Alert, Oriented x4
Insight	: No grossly impaired insight
Judgment	: No grossly impaired judgment

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP
Event Time: Thu, 19 Jul 12 1145 Status: corrected

Thu, 19 Jul 12 1232 Documented by Steven Konrad, MD

Start Time of IP Assmnt: 9 Jul 12 1000
Source of Referral : Jail, lockup, penetentiary, or DOC-state
Sources of Information : Patient,Facility computerized records
Barriers to Assessment : None
Consenting Party : patient consents or involuntary treatment
Preferred Language(s): English

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd admissions.

Mr. Hale is at chronically elevated risk of danger to others on the basis of his history of violence. Currently, he is irritable at times and possibly paranoid, but he has been calm and behaviorally in control for the majority of his admission and his acute risk of violence has been mitigated by his medication compliance. He faces the significant stressors of his legal situation and apparently difficult family relationships, which place him at chronically elevated risk of danger to self. However, his acute risk of deliberate harm to self is currently assessed to be low as he denies thoughts of self-harm and voices future orientation around fighting his legal case.

Axis I : Paranoid type schizophrenia, chronic
Axis II : Diagnosis Deferred on Axis II
Axis III : Routine general medical examination at a health care facility
Axis IV : Problems related to interaction with the legal system/crime
Axis V : current 55
Discharge Diagnosis : Paranoid type schizophrenia, chronic
Housing Type : Correctional
Housing Specific : AMKC
Aftercare Type : Follow-up Onsite
Aftercare Specific : Corizon
Pt Agrees with Dispo : patient agrees with disposition
Family/Cth Invlvd in Dispo: no family/other involved in disposition
Discharge Documentation : now
Rationale for Discharge : Presenting symptoms adequately resolved for release
Multiple Antipsychotics : One antipsychotic agent
Attending Discharge Signature : i have reviewed and agree with the discharge summary

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Chief Complaint : "I don't know what happened"

History of Present Illness (WP): Patient is a 26 year old AAM with reported history of schizophrenia and prior inpatient treatment, arrested in April 2012 for alleged attempted murder of a officer (stabbing) who was called to his home by him and/or his mother, admitted in April while under NYPD custody to 19N, then on 19 West for 2 weeks at the end of June discharged 7/2/12 with initial concerns of mood lability and agitation. He is now referred back to CFES this morning after assaulting a clinician on his unit unprovoked. While assaulting this clinician other inmates allegedly came to her aid, further altercations ensued, and patient was taken to Elmhurst for medical clearance. He was cleared with medical exam remarkable for a nasal septum fracture.

On clinical exam patient is calm, with poor eye contact and nearly inaudible, has to be asked to repeat himself. He presents with latent response to most questions. Patent described his mood as poor and continued to repeat that he needs help and that no one would give him his medication. He was not able to coherently relate the events preceding the assault other than stating that he wanted his medication but no one would give it to him. He then reported that he hit the clinician, but could not elaborate further on why or what he thought would be the consequence of the assault. Patient reported that he has remained irritable, depressed, and angry. He had difficulty organizing thoughts and reported that he is "mentally sick." He denied current experience of manic symptoms including racing thoughts, decreased need

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

for sleep, and increased energy. Patient denied auditory and visual hallucinations. He does not elicit frank delusional content. Paranoid ideation was noted in patient's continued report that people are not trying to help him and were keeping him from getting treatment, specifically medication. Patient denied current suicidal or violent ideation.

Patient reported that he last took medication at Bellevue and has not taken it since. Collateral from Dr. Selling indicated that patient was seen by MD on arrival back to Rikers on 7/2/12 and meds were continued though patient's compliance was doubted. Dr. Selling reiterated that the patient assaulted this clinician unprovoked in her office after another inmate left after a session. The clinician was knocked and her eye was split open secondary to this alleged assault.

On re-assessment 7/9/12:
Progress notes from the first weekend of admission were reviewed. The patient remained calm and cooperative with staff and was mostly isolative to his room. His facial pain was controlled with Motrin PRN. He was complaint with all prescribed medications. On approach the morning of 7/9/12, he acknowledged this writer as his MD from his recent 19 West admission. When asked why he was referred back to the hospital he reported that he was not being offered any medications at Rikers Island. While this is not the report from the Rikers Island referral. Rikers staff report that he has been non-adherent with medications. The patient declined to get out of bed for a

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

full admission interview. He stated, "You already know all about me from last week...I want to sleep." He then turned over in bed and terminated the conversation.

On Re-assessment on 7/10/12:
On admission, the patient declined to talk with the team. However, he has since agreed to share information. Since his recent discharge from BHC last week, he reported that he was not receiving his meds upon return to Rikers. He was not able to articulate any particular reason why he assaulted the clinician at Rikers, other than to say, "I didn't know what I was doing because I wasn't on my meds." We discussed the option of starting Prolixin Decanote in lieu of oral Prolixin. He was ambivalent, but agreed.

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Prior Mental Health Srvcs : Outpatient mental health provider,Psychiatric inpatient unit,State psychiatric hospital

AOT Status : no aot involvement

High Risk Psychiatric Hx : Violence or endangering others,Arrest or incarceration,Treatment noncompliance

Psychopharm History : Drug Name: prolixin Dosage and Compliance: 5mg bid
Drug Name: latuda Dosage and Compliance: up to 80mg daily
Drug Name: depakote
Drug Name: cogentin

Past Psychiatric History (WP): As per chart review from 4/17 admission to 19 N - Collateral from the patient's mother, Mrs Hale:

"She stated that she first noticed that he needed mental health treatment when Mr. Hale was 16/17, and that he was "arguing, acting out, angry, and thought that people were after him." She also described him as cutting hinself off from friends around this time. Mrs. Hale reported that Mr. Hale carries a diagnosis of "bipolar schizophrenia," and that her brother has "the same thing." She further provided that Mr. Hale was first hospitalized at around 16/17 at Mount Sinai MC, and that he has had 5 or 6 subsequent hospitalizations, including one at Rockland Psychiatric Center. When questioned about the incidents that prompted these hospitalizations, Mrs. Hale described agitated, aggressive, and paranoid behavior. She also stated that Mr. Hale has become violent while in psychiatric hospitals. Mrs. Hale stated that the patient has been arrested multiple times, probably for the first time around 2002, typically for "fighting." She stated that he has never been sentenced/mandated to any kind of treatment program, and has never received AOT"

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

With regard to his recent symptoms that led to his hospitalization on 4/17:

"Mrs. Hale explained that Mr. Hale has a history of psychiatric medications that includes Thorazine, Depakote, and a medication to combat "shaking," and he has presently been taking Latuda 80mg. He had recently been prescribed Latuda 40mg by Dr. Nunes at the St. Mark's Clinic, but Mrs. Hale felt that this was not adequate, and began giving her son the medication of a stronger dosage that was left over from a previous prescription. Mrs. Hale stated that Mr. Hale was "fine" and "happy" until around Easter approximately 2 weeks ago. She explained that he was "withdrawn," "sad," and "not sleeping." She explained that he would take 4-5 hour "catnaps" each day, and that she would give him leftover Trazodone that he was prescribed at one time"

Patient was previously followed by Dr. Nunes at St. Mark's Clinic, for outpatient treatment, where he was diagnosed with schizophrenia. Past medication trials have included Prolixin, Cogentin, Depakote, Thorazine, Haldol, and Latuda.

While hospitalized on 19N, Mr. Hale was reportedly irritable, guarded, isolative and uncooperative. No dangerous behaviors were observed, nor were any overt symptoms of psychosis. Prolixin 5 mg twice daily was restarted which the patient was compliant with.

Per his most recent BHC admission to 19 West in June 2012: [Mr. Hale was referred from Rikers on 6/19/12 due to concerns about agitation, lability, and threatening behavior

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DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

at AMKC. On admission evaluation he was logical and coherent but terse. He admitted to "losing his temper" due to what he described as repeated housing changes at Rikers, and expressed wanting to be on medications that better controlled his temper. He appeared apathetic about his court case and voiced eating and sleeping disturbances, also related to housing changes at Rikers. He denied thoughts of self-harm or violence, denied hallucinations. He agreed to voluntary admission to 19W. His medications at Rikers were listed as Prolixin 5mg bid, Buspar 5mg bid, Cogentin 1mg bid, Depakote 500mg qam and 1000mg at bedtime, trazodone 100mg at bedtime, and these were restarted on admission. He has been accepting these medications.

On inpatient reassessment on 6/20/12, Mr. Hale was terse, irritable, guarded, required significant encouragement to elaborate on his responses, nevertheless was coherent, logical, goal-directed. The content of his statements was mainly remarkable for externalization and an oppositional stance. He again denied thoughts of self-harm or violence, denied current hallucinations, and did not voice any frankly delusional material, however as the interview progressed he began to make statements about people hating him and wanting to kill him, about DOC and other inmates trying to provoke him, and about being like Jesus Christ (but not being Jesus Christ himself) and dying for his family. He specifically stated that he would never kill himself, but that "I'm just waiting for someone to do it for me." Other than these paranoid-sounding statements and his guarded stance, there were no clear objective

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Unscheduled Discharge Summary-Psych IP -- cont'd

indicators of acute mania, psychosis, or neurovegetative depression. He voiced feeling "sick mentally" and wanting his medications to be adjusted to better target his symptoms, but had difficulty elaborating on what he specifically wanted help with.

On the afternoon of 6/21/12, Mr. Hale stated he felt like "punching someone in the face," but was calm after receiving prn medications. On 6/22/12, he was observed by staff pacing angrily in the hallway, pushing past and throwing elbows at peers and staff, and had an angry confrontation with a disorganized peer. Staff who intervened and spoke with him reported that he felt that the hospital staff were in league with DOC staff in trying to provoke him. He expressed feeling frustrated about being in the hospital and about his legal situation, and wanting to return to Rikers for more food and greater freedom of movement, but agreed to stay for further treatment. He continued to appear tense over the weekend but was less irritable and more verbal with peers and staff, and was able to request prn medication on Sunday. On 6/25/12, he was able to tolerate a long discussion with his primary therapist about the reasons for his repeated presentations to Bellevue and about continuing his stay in order to work on how to cope with his situation at Rikers given the nature of his legal case, and he said he would consider this. He was oddly related, with an odd smile, but not overtly psychotic, manic, or depressed.

During his second week of admission, Mr. Hale was minimally engaged with staff. When approached, he responded tersely to questions, generally denied any complaints, at times

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Attending Physician	D.O.B.
Konrad, Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

spoke about feelings of frustration around his incarceration and legal situation but declined to meet for psychotherapy sessions to address his coping skills, and frequently asked to be left alone. He was noted to enjoy recreational groups, but did not attend any therapeutic groups despite encouragement. At times he was more irritable, but at other times he was observed with an odd smile. He continued to be free of any overt signs of psychosis, mania, or depression. He accepted his standing medications and requested prn medications infrequently. There were no behavioral incidents, and he was able to calmly relate to his treatment team that he wished to return to Rikers so that he could have greater freedom of movement and because he felt that would help him move forward with his legal case. By 7/1/12 Mr. Hale was assessed to be stable for stepdown to outpatient management at Rikers Island, and was discharged to AMKC.

Medications on discharge:
Depakote 500mg am/1000mg pm (VPA level on 6/26 = 129)
Prolixin 5mg twice daily
Buspar 7.5mg twice daily
Cogentin 1mg twice daily
trazodone 150mg at bedtime]

Substances of Abuse : Cannabis (Marijuana) still using First: unk
Last: days-wks before admission [utox pos for THC]
Alcohol (Ethanol, etc.) still using

Complicated Withdrawal : No history of complicated withdrawal

Effects of Substance Use : Exacerbation of pyschiatric symptoms, Reduced daily functioning

Chemical Abuse History (WP): Patient reports that he formerly smoked cannabis several times a week, and routinely consumed etoh on weekends.

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Unscheduled Discharge Summary-Psych IP -- cont'd

Abuse History : unable to assess
Current Effects of Abuse: Unable to assess
Developmental Hx (WP) : As per chart review

"As per admission note the patient grew up without a father; he is single and has two children ages 4 and 3 (patient said their ages are 3 and 5 years and that they are girls) living with patient's mother and girlfriend. Patient eloped from school from 9th grade and he was in special education. The patient is in SSI."

Family History Categories: Unable to assess
Version : retention documentation
Residence Selection : adult
ACS/APS Involvement : unable to assess
Historical Risk Factors: Suicide Hx: Chemical abuse or dependency (current or past),Recent discharge from psychiatric admission Violence Hx: Chemical abuse or dependency,History of arrest, DWI, or moving violations,History of violence,Intentional harm of others,Psychiatric hospitalizations,Recent violence Suicide Risk Mitigation: Ability to form positive therapeutic relationships,Past treatment adherence or success,Sense of responsibility to family,Social network, supports, or treatment
Current Risk Factors : Suicide Cr: None of the listed suicide risk factors Violence Cr: None of the listed violence risk factors

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DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Admission Date : Fri, 06 Jul 2012

Admitting Diagnosis : Paranoid type schizophrenia, chronic with acute exacerbation (295.34)

Hospital Course (WP): Mr. Hale was re-admitted back to 19 West on 7/6/12 after he assaulted staff at Rikers Island. Upon arrival to the unit, he was reluctant to speak with the treatment team. However, on HD#2, he sat down to discuss his readmission with the team. He reported that he asked for his medications upon arrival to Rikers Island last week after discharge from 19W. He reported that he was denied his medications by Rikers staff and he became upset. He stated, "I need my meds and they wouldn't give them to me...I was out of it and I guess I hit that lady because I didn't have any meds." Per conference with Rikers staff, the patient was offered medications, but refused to take them.

Mr. Hale agreed to immediately restart his prior regimen of Prolixin 5 mg BID and Depakote 500 mg qAM and 1000 qPM. On admission, he denied all active psychiatric symptoms and did not demonstrate any objective signs of active illness. Similar to his recent admission, he acclimated quickly to the unit and was cooperative with staff. He was mostly isolative to his room.

His mother came to visit on HD#2 and provided information. She reported that Mr. Hale does not like being at Rikers Island. He told her that he was denied his medications and she was very upset by this. He pleaded for Bellevue staff to keep him in the hospital for a few months so that he could avoid Rikers Island.

Mr. Hale agreed to switch from oral Prolixin to Prolixin Decanoate. He received his first injection of 12.5 mg on 7/11/12. He received his 2nd injection of 25 mg on 7/18/12. He will be due for another 25 mg injection on 7/25/12 and will continue this every 2 weeks. His VPA level on 7/17/12 = 70.3. Mr. Hale did

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Formulation (WP) : Mr. Terrance Hale is a 26yo AAM charged with alleged Attempted Murder of a Police Officer stemming from events in April 2012 that were highly publicized at the time, with history of multiple psychiatric hospitalizations since age 18 in the context of aggression and paranoia, violence both while hospitalized and in the community, substance use, known to 19N from two brief admissions shortly after arrest. He returned to 19W on 6/19-7/2/12 for voluntary admission after being referred from Rikers for "extreme lability" and threatening behavior. During his two weeks on the unit, he was terse and guarded, as well as oddly related, with an odd smile at times, and is irritable at other times. However, he was calm, coherent, logical, organized, and not overtly psychotic, manic, depressed, or anxious. He explained that his agitation at Rikers prior to admission was triggered by the fact that his housing had been changed recently, which caused him to feel that he was being provoked. He expressed feeling frustrated and stressed by his legal situation, and spoke about feeling targeted by others in the jail setting due to his high-profile charges. While these statements may reflect paranoid ideation, they may also have a basis in reality given the nature of his case. At any rate, he was minimally engaged in individual psychotherapy or in therapeutic groups. He accepted his standing medication and voices feeling "better" than on admission. He re-admission on 7/6/12, is in the setting of assaulting a clinician at Rikers Island. The patient reports that this was in the setting of not being offered his standing med regimen at Rikers. This is conflicting information as Rikers reports that he is non-adherent.

Diagnostically, collateral information gathered on prior admissions to 19N and from the patient's mother during this admission indicates a history of diagnosis with psychotic illness, specifically

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Unscheduled Discharge Summary-Psych IP -- cont'd

Schizophrenia, Paranoid Type. During the 2 most recent 19W admissions, no overt signs of acute psychosis or any other acute major mental illness were observed. Axis II pathology is a larger focus of this current 19W admission. Antisocial traits have been identified on past admissions. It is very likely that the patient also has some secondary gain to act out violently at Rikers to avoid incarceration and gain admission to a hospital.

Mr. Hale is at chronically elevated risk of danger to others on the basis of his history of violence. Currently, he is calm and behaviorally in control and has been so for this entire admission. His acute risk of violence has been mitigated by his hospitalization and medication compliance. He faces the significant stressors of his legal situation and apparently difficult family relationships, which place him at chronically elevated risk of danger to self. However, his acute risk of deliberate harm to self is currently assessed to be low as he denies thoughts of self-harm and voices future orientation around fighting his legal case.

Axis I : Paranoid type schizophrenia, chronic
Axis II : Antisocial personality disorder
Axis III : Routine general medical examination at a health care facility
Axis IV : Problems related to interaction with the legal system/crime
Axis V : current 55
Discharge Diagnosis : Paranoid type schizophrenia, chronic with acute exacerbation
Housing Type : Correctional
Housing Specific : Rikers GRVC
Aftercare Type : Follow-up Onsite
Aftercare First Appt : Thu, 19 Jul 2012
Pt Agrees with Dispo : patient agrees with disposition
Family/Oth Invlvd in Dispo: family/other involved in disposition
Family/Oth Invlvd Contact : mother

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Discharge Summary-Psych IP -- cont'd

Discharge Documentation	:	now
Rationale for Discharge	:	Presenting symptoms adequately resolved for release
Medication Side Effects	:	None
Multiple Antipsychotics	:	One antipsychotic agent
Attending Discharge Signature	:	i have reviewed and agree with the discharge summary

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* * * End of Report * * *

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19N-14-A	Hale,Terrance	3501306	3501306-2	27Y	M

Attending Physician: Roth,Loren
D.O.B.: 02/25/1986

Gamma Glutamyl Transferase Level Serum

Collection Time: Unknown
Collected by: Unknown
Specimen: SST(26688549)
Result Time: 21 Apr 12 1940
Resulted by: Healey,M
Status: complete

GGT (IU/L) : 99 (15 - 85)

Magnesium Level Serum

Collection Time: Unknown
Collected by: Unknown
Specimen: SST(26688549)
Result Time: 21 Apr 12 1955
Resulted by: Healey,M/Amin,A/Healey,M
Status: complete

Mg (mEq/L): 2.2 (1.3 - 1.9)

Thyroid Stimulating Hormone Level w/rflx to fT4 & fT3 Serum

Collection Time: Unknown
Collected by: Unknown
Specimen: SST(26688549)
Result Time: 21 Apr 12 1949
Resulted by: Amin,A/Healey,M
Status: complete

Remark : Spec #26688549: (unknown)
Diagnosis : Paranoid type schizophrenia, chronic
TSH (uIU/mL) : 1.923 (0.35 - 4.8)

Syphilis Treponemal Ab,IgG w/rflx to RPR/Titer/TPPA Conf.

Collection Time: Unknown
Collected by: Unknown
Specimen: SST(26688549)
Result Time: 23 Apr 12 1259
Resulted by: Pradhan,S
Status: complete

Remark : Spec #26688549: (unknown)
Syphilis IgG Ab : non-reactive (non-reactive)
Syph STD Comment: No Serological evidence of infection with T.pallidum (incubating or early primary syphilis cannot be excluded). Retest in 2-4 weeks if clinically indicated.

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

least 2 appropriate alternatives to aggression in coping with interpersonal difficulties during 1st week of admission.

Assessment/Plan (WP) : 1. Dangerousness: He is currently calm and cooperative. No SI or HI. He is stable for q15 minute checks, A zone, routine prns.
2. Possible psychosis +/- mood symptoms: Continue medications as at Rikers. Prolixin 5 mg BID, Depakote 500 mg AM, 1000 mg PM, Buspar 7.5 mg BID, Cogentin 1 mg BID. Assess whether patient able to engage in individual and group therapy; on his two prior admissions he was minimally engaged in all treatment recommendations.
3. Medical: Admission H&P reviewed. No acute issues noted. Admission CXR, & EKG were normal. Labs were not grossly outside of normal limits.
4. Legal: 9.13 admission. Charged with Attd Murder of a Police Officer. Next court date 7/11/12.

Last Attending Comment: danger to others
Version : retention documentation
Advance Directives : does not wish
Discharge Documentation : later
Discharge Documentation : later
Sections Reviewed: I have reviewed the entire assessment

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

should also be considered. The provisional diagnosis is Psychosis NOS. Axis II is deferred pending further evaluation but personality factors have been identified on past admissions.

Mr. Hale is at chronically elevated risk of danger to others on the basis of his history of violence; he is irritable and possibly paranoid and was recently described as acutely labile and threatening at Rikers, suggesting an acute elevation in this risk. However, he is calm and behaviorally in control now. He is at low risk of deliberate harm to self as he denies thoughts of self-harm, however he does face the significant stressors of his legal situation and apparently difficult family relationships, and describes himself as "depressed."

Axis I : Unspecified psychosis
Axis II : Diagnosis Deferred on Axis II
Axis III : Routine general medical examination at a health care facility
Axis IV : Problems related to interaction with the legal system/crime
Axis V : current 40
Dx(es) for Presnt Problem(s) : : PhD : Danger to others Evidence: -Pt referred from Rikers for lability and threatning behavior. -Pt has history of violence and aggression while hospitalized and in the community. -Pt voices paranoid thoughts. Goals: S) Pt will no longer present a danger to others.L) Pt will be able to manage difficult interpersonal situations without recourse to violence. Objectives: -Pt will not voice paranoia for at least 5 consecutive days during 1st week of admission. -Pt will not engage in any verbally aggressive or physically violent behavior during 1st week of admission. -Pt will not require IM stat medication, seclusion, or restraint during 1st week of admission. -Pt will articulate at

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled History and Physical (Adult) (new) (no cf) -- cont'd

distant or oddly related to the examiner, soft speech, disorganized thought, no thoughts of harming self or others,

---------- : Superior --> Inferior
Head : normocephalic, normal facies,
Eyes : sclera anicteric, pupils equal round and reactive to light, extraocular movements intact,
Nose and Throat : clear turbinates, normal mucosa, no exudates, good dentition, + nasal awelling + nasal congestion, dried blood to nares pt denied new bleeding denies pain ,
Neck and Lymph : neck supple, no JVD, no lymphadenopathy,
Thorax and Lungs : clear to ascultation bilaterally,
Cardiovascular : regular rate, normal S1, S2, no extra sounds, murmurs, or rubs,
Breasts : no gynecomastia,
Abdomen : non-distended, bowel sounds present, non-tender, no rebound or guarding, no hepato-splenomegaly, no masses,
Genitalia : genital exam deferred,
Anus and Rectum : deferred anal and rectal exam,
---------- : Surface --> Deep
Skin : no rashes or lesions,
Peripheral Vascular: pulses 2+ throughout, no clubbing or cyanosis of nails, or edema,
Axial Trauma/Wounds: head atraumatic, no axial trauma or wounds evident to superficial body survey,
Limbs Trauma/Wounds: no trauma or wounds on limbs evident to superficial exposure,
Musculoskeletal : no gross musculoskeletal defects or impairments, no costo-vertebral angle tenderness,
Neurological : CN II-XII grossly intact, strength 5 throughout, sentation grossly intact to light touch, reflexes 2+ and symmetrical throughout,

Radiology Results : Chest Xray June 19, 2012- normal chest
Cardiology Results : Sinus tachycardia hr 102 Pt denies chest pain and is snoring during exam
Other Results : LABS FROM ELMHURST USED
Most Recnt Vitl Signs : T 97, P 82, R 18, BP 135/90, O2 Sat 98 (07/06

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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled History and Physical (Adult) (new) (no cf) -- cont'd
06:49

Vascular Lines	: no vascular lines
Line Status	: No vascular lines
Brief Summary	: 26 y/o male history of paranoid schizophrenia admitted 9.39 to psychiatry
Dx(es) for Presentatn	: Paranoid type schizophrenia, chronic with acute exacerbation
Select Dx(es) at Admit	: none,
DVT/PE Risk Assessment	: Age: 18-40 Age Score: 0 Pre-Existing: None (Score = 0) Current: None (Score = 0) In-Hospital: None (Score = 0) Absolute Contraindications: None Relative Contraindications: None Risk Score: 0
Problem(s)	: : PhD ; Danger to others Evidence: recent unprovoked assault of clinician Goals: impulse control and treatment adherence Objectives: Patient will not be an acute danger to others
Assessment/Plan (WP)	: Nasal fracture- Plastics consult upwards Sinus tachycardia- repeat EKG tomorrow 7/7/12 Abnormal WBC- pt asymptomatic repeat hemogram 7/7/12 Bodyaches- motrin 600mg po q8h prn
Author	: Shawn Marie Jackson, NP

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DIS-19W-69-C	Hale, Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad, Steven	02/25/1986

Unscheduled Multidisciplinary Treatment Plan (Psychiatry) IP -- cont'd

Murder 1st Degree. Next court appearance on 7/11/12.

RN Interventions (WP) : Problem: Danger to Others (Violent) As evidenced by: patient hitting a clinician at Rikers.

Goal: Will not display violent behavior towards others.

Objective: Will not threaten staff and will not attack staff in 2 hours.

Interventions:
1. Establish therapeutic relationship, display honesty and consistency.
2. Firm limit setting - verbal and physical limits to client's hostility.
3. Use nonjudgmental, respectful and consistent communication approach.
4. Encourage to verbalize inner feelings and thoughts- esp. angry feelings.
5. Administer medications ordered by MD.
6. Provide activities that require very little attention.

SW Interventions (WP) : 1. Obtain collateral information. 2. Will meet with patient for a total of 30 minutes a week for support, psycho-education, discussion of legal issues, and aftercare planning.

AT Interventions (WP) : Dance/Movement Therapy 3x/week, Open Leisure 3x/week, Bingo 1x/week, Music Appreciation 3x/week, Spirituality 1x/week, Recovery 1x/week,

Assessment/Plan (WP) : 1. Dangerousness: The patient is at chronically elevated risk for violent behaviors. He is currently calm, cooperative and denies SI and HI. Although he does not require 1:1 observation, he will be monitored closely on q15 minute checks in a high observation room in Area A. PRN Prolixin and Ativan for aggressive behaviors.
2. Psychosis: Continue prior medication regimen of Prolixin 5 mg BID, Depakote 500 mg qAM / 1000 mg qPM, and Trazodone 100 mg at bedtime. Klonopin was added on this admission for additional impulse control.

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
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Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Multidisciplinary Treatment Plan (Psychiatry) IP -- cont'd to psychosis Evidence: Assult of clinician at Rikers island Goals: S) Pt will no longer present a danger to others.L) Pt will be able to manage difficult interpersonal situations without recourse to violence. Objectives: Pt will not engage in any verbally aggressive or physically violent behavior for at least 7 consecutive days.-Pt will not require IM stat medication, seclusion, or restraint for at least 7 consecutive days. -Pt will attend Violence Reduction group at least twice during 1st 2 weeks of admission.-Pt will identify at least 4 triggers for violent thoughts during 1st 2 weeks of admission.-Pt will articulate at least 2 appropriate alternatives to aggression in coping with interpersonal difficulties during 1st 2 weeks of admission. -Pt will accept 100% of standing antipsychotic (or mood-stabilizing) medication for at least 7 consecutive days.

MD Interventions (WP) : 1. Dangerousness: The patient is at chronically elevated risk for violent behaviors. He is currently calm, cooperative and denies SI and HI. Although he does not require 1:1 observation, he will be monitored closely on q15 minute checks in a high observation room in Area A. PRN Prolixin and Ativan for aggressive behaviors.
2. Psychosis: Continue prior medication regimen of Prolixin 5 mg BID, Depakote 500 mg qAM / 1000 mg qPM, and Trazodone 100 mg at bedtime. Klonopin was added on this admission for additional impulse control. Will initiate a taper from 1 mg BID. Will discuss the option of Prolixin Decanoate.
3. Medical: Admission physical exam reviewed. The patient sustained a nasal bone fracture in an altercation at Rikers. Pain control with Motrin and ice packs PRN. Admission labs notable for mild elevation of AST/ALT. CXR from June 2012 was unremarkable. EKG QTc = 433.
4. Legal: 9.39 admission. Charged with Attempted

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

Prior Mental Health Srvcs : Outpatient mental health provider,Psychiatric inpatient unit,State psychiatric hospital

AOT Status : no aot involvement

High Risk Psychiatric Hx : Violence or endangering others,Arrest or incarceration,Treatment noncompliance

Psychopharm History : Drug Name: prolixin Dosage and Compliance: 5mg bid
Drug Name: latuda Dosage and Compliance: up to 80mg daily
Drug Name: depakote
Drug Name: cogentin

Past Psychiatric History (WP): As per chart review from 4/17 admission to 19 N - Collateral from the patient's mother, Mrs Hale:

"She stated that she first noticed that he needed mental health treatment when Mr. Hale was 16/17, and that he was "arguing, acting out, angry, and thought that people were after him." She also described him as cutting himself off from friends around this time. Mrs. Hale reported that Mr. Hale carries a diagnosis of "bipolar schizophrenia," and that her brother has "the same thing." She further provided that Mr. Hale was first hospitalized at around 16/17 at Mount Sinai NC, and that he has had 5 or 6 subsequent hospitalizations, including one at Rockland Psychiatric Center. When questioned about the incidents that prompted these hospitalizations, Mrs. Hale described agitated, aggressive, and paranoid behavior. She also stated that Mr. Hale has become violent while in psychiatric hospitals. Mrs. Hale stated that the patient has been arrested multiple times, probably for the first time around 2002, typically for "fighting." She stated that he has never been sentenced/mandated to any kind of treatment program, and has never received AOT"

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DIS-19W-62-A	Hale, Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad, Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

With regard to his recent symptoms that led to his hospitalization on 4/17:

"Mrs. Hale explained that Mr. Hale has a history of psychiatric medications that includes Thorazine, Depakote, and a medication to combat "shaking," and he has presently been taking Latuda 80mg. He had recently been prescribed Latuda 40mg by Dr. Nunes at the St. Mark's Clinic, but Mrs. Hale felt that this was not adequate, and began giving her son the medication of a stronger dosage that was left over from a previous prescription. Mrs. Hale stated that Mr. Hale was "fine" and "happy" until around Easter approximately 2 weeks ago. She explained that he was "withdrawn," "sad," and "not sleeping." She explained that he would take 4-5 hour "catnaps" each day, and that she would give him leftover Trazodone that he was prescribed at one time"

Patient was previously followed by Dr. Nunes at St. Mark's Clinic, for outpatient treatment, where he was diagnosed with schizophrenia. Past medication trials have included Prolixin, Cogentin, Depakote, Thorazine, Haldol, and Latuda.

While hospitalized on 19N, Mr. Hale was reportedly irritable, guarded, isolative and uncooperative. No dangerous behaviors were observed, nor were any overt symptoms of psychosis. Prolixin 5 mg twice daily was restarted which the patient was compliant with.

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

since age 18 in the context of aggression and paranoia, violence both while hospitalized and in the community, substance use, known to 19N from two brief admissions shortly after arrest. He now returns to 19W for voluntary admission after being referred from Rikers for "extreme lability" and threatening behavior. He is terse, irritable, guarded, seems to be adopting an oppositional and externalizing stance, nevertheless is calm, coherent, logical, organized, denying symptoms of acute mania or psychosis. He expresses feeling "sick mentally" and "upset, depressed, stressed" but attributes this mainly to feeling provoked, for example because he was recently moved to a new housing situation at Rikers. He made other statements about people hating him and wanting to kill him, and these as well as his guarded stance may reflect underlying psychotically-driven paranoid ideation. However, his paranoia may also be reality-based given the nature of his charge, and in fact he is on a DOC 1:1. He expresses wanting "help" and feeling that his medications are not working, but cannot explain what specific issues he would like help with, or what symptoms he feels are not being fully treated.

Diagnostically, collateral information gathered on prior admissions to 19N indicates a history of diagnosis with Schizophrenia and "bipolar schizophrenia." However, during those admissions no overt signs of psychosis or any other major mental illness were observed. This is consistent with his presentation on interview today, which other than paranoid-sounding statements and a guarded stance was remarkable only for irritability. It should be noted that the patient reports he has been compliant with antipsychotic and mood-stabilizing medications at Rikers, so it is possible that he is presenting with a symptom picture that is attenuated. Given the serious nature of his charge and/or other as yet unidentified secondary gain, symptom exaggeration

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Chart Review Print

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DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

Formulation (WP) : ON ADMISSION 6/19/12:
26 yo AAM with reported hx of schizophrenia and prior inpat treatment, arrested in april 2012 for alleged attempted murder of an officer [stabbing] who was called to his home by him and/or his mother, admitted in April while under NYPD custody to 19N, referred back to Bellevue because of concerns about agitation and lability. Pt has a significant history of psychiatric treatment as well as poor impulse control and prior trials of mult medications. During his admissions to 19N in April, he was oddly related at times and showed poor impulse control. There appears to be elements of both Axis I and Axis II traits. Per referral, pt has been difficult to manage at the jail, and pt is now agreeing that he would benefit from medication adjustment to address his impulse control. As such, will sign pt in 9.13. Of note, I encouraged pt to comply with tx team and to approach tx team in a calm and controlled manner with any problems, such as if he changes his mind and wants discharge [pt was able to be discharged last time after he requested discharge and showed a period of controlled behavior]. Risk of harm to self is considered low at this time - pt denies hx of suicidal behavior. However, he has risk factors such as social isolation and hopelessness about his attempted murder charge and possible conviction. Risk of harm to others is considered low to moderate right now but moderate to high/moderate in general - pt has history of drug abuse, violence and arrest, with what appears to be little regard for the feelings of others [as observed throughout the time on 19N]. However, right now he is calm and complying with admission procedures, agreeing with admission.

INPATIENT REASSESSMENT 6/20/12:
As above, 26yo AAM charged with alleged Attempted Murder of a Police Officer stemming from events in April 2012 that were highly publicized at the time, with history of multiple psychiatric hospitalizations

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

Historical Risk Factors: Suicide Hx: Chemical abuse or dependency (current or past),Impulsive or reckless behavior,Major mental illness or personality disorder,Past suicidal ideation,Relationship instability Violence Hx: Chemical abuse or dependency,History of arrest, DWI, or moving violations,History of violence,Psychiatric hospitalizations,Unemployment or repeated job losses,Violence during prior psychiatric inpatient treatment Suicide Risk Mitigation: Reality testing ability

Current Risk Factors : Suicide Cr: Depressed,Relationship instability Violence Cr: Paranoid delusions or perceived threat,Poor impulse control Self-Care: None of the indicators of poor self-care

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

Substances of Abuse : Cannabis (Marijuana) still using First: unk Last: days-wks before admission [utox pos for THC]
Alcohol (Ethanol, etc.) still using
Complicated Withdrawal : Unable to assess
Effects of Substance Use : Unable to assess
Chemical Abuse History (WP): Patient reports that he formerly smoked cannabis several times a week, and routinely consumed etoh on weekends.
Abuse History : unable to assess
Current Effects of Abuse: Unable to assess
Developmental Hx (WP) : As per chart review

"As per admission note the patient grew up without a father; he is single and has two children ages 4 and 3 (patient said their ages are 3 and 5 years and that they are girls) living with patient's mother and girlfriend. Patient eloped from school from 9th grade and he was in special education. The patient is in SSI."

Family History Categories: Unable to assess
Version : retention documentation
Residence Selection : adult
ACS/APS Involvement : unable to assess
Appearance : Appears stated age,Adequately dressed,Adequate grooming
Behavior : Indifferent,Distant relatedness
Speech : Normal rate,Normal volume,Normal rhythm,Non-pressured
Thought Process : Goal directed,Logical
Thought Content : Paranoid ideation
Suicidal Ideation : No suicidal ideation
Aggressive Ideation : No aggressive or homicidal ideation
Perceptual Disorders : No perceptual disorders
Mood : Irritable
Affect : Constricted
Impulse Control : Intact impulse control
Cognitive Function : Alert,Oriented x4
Insight : Impaired insight
Judgment : Impaired judgment

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-69-C	Hale,Terrance	3501306	3501306-4	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Multidisciplinary Treatment Plan (Psychiatry) IP -- cont'd
Will initiate a taper from 1 mg BID. Will discuss the option of Prolixin Decanoate.
3. Medical: Admission physical exam reviewed. The patient sustained a nasal bone fracture in an altercation at Rikers. Pain control with Motrin and ice packs PRN. Admission labs notable for mild elevation of AST/ALT. CXR from June 2012 was unremarkable. EKG QTc = 433.
4. Legal: 9.39 admission. Charged with Attempted Murder 1st Degree. Next court appearance on 7/11/12.

Last Est Date of Disc : Tue, 17 Jul 2012
Est Date of Discharge : Tue, 17 Jul 2012
Impediments to Disch : Violence History Forensic History
Patient Involvement : The patient is engaged in his treatment planning.

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* * * End of Report * * *

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Chart Review Print

Location	Patient Name	Patient Number	Visit Number	Age	Sex
DI8-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician	D.O.B.
Konrad,Steven	02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

Chief Complaint : "I'm feeling sick mentally"

History of Present Illness (WP): ON ADMISSION 6/19/12:
26 yo AAM with reported hx of schizophrenia and prior inpat treatment, arrested in april 2012 for alleged attempted murder of an officer [stabbing] who was called to his home by him and/or his mother, admitted in April while under NYPD custody to 19N, referred back to Bellevue because of concerns about agitation and lability. The pt was treated for a few days on 19N after the arrest, then was discharged to arraignment, then was returned to Bellevue approx 24 hrs later for agitation. He was readmitted to 19N where he remained for 9 days. During that time he had 2 doses of IM medication for behavior which was felt to be related to poor impulse control but not necessarily psychosis. Pt was noted at times to be oddly related and laughing to himself. He was eventually discharged on april 30 at his own request when he had shown calm behavior. He has been at Rikers since then. Meds at Rikers are currently Prolixin 5mg bid, buspar 5mg bid, Cogentin 1mg bid, Depakote 500mg qam and 1000mg at bedtime, Trazodone 100mg at bedtime. On this interview, pt is very quiet and stern, answering questions coherently and in a terse manner with poor eye contact. He admits upon questioning that he became 'upset' after a conversation 'with my family' - clarification reveals that he is in fact referring to his mother, with whom it seems he has a complicated relationship [she frequently called 19N last time and also reportedly calls doctors at Rikers in the recent past]. Pt would not elaborate on how he acted when he was 'upset', but referral indicates that 'he has been

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Location	Patient Name	Patient Number	Visit Number	Age	Sex
DIS-19W-62-A	Hale,Terrance	3501306	3501306-3	27Y	M

Attending Physician: Konrad,Steven
D.O.B.: 02/25/1986

Unscheduled Psychiatric Assessment IP -- cont'd

extremely labile, ... they had to lock down his cell area due to an angry outburst where he threatened all the other patients in his housing area.' Asked if felt that his being 'upset' was related to his illness [he endorses having an illness], he said no, he thought it was about losing his temper. He confirms that he does, in fact, want help in being on medication that will help him control his temper. Of note, he feels he should not be 'blamed' for his temper, as 'it's the doctor's fault for not putting me on the right medication.' Pt denies SI, HI and AVH, although he does report that, at times, he wonders if perhaps he should not be alive. His next court date is July 11 and he appears apathetic about that, as though he has some hopelessness about the situation. He reports his sleep has been difficult and he has not been eating well [reason: he has been moved from one housing area to another recently, and he states that when that happens, other inmates tend to take your food when you're new to the housing area]. Pt signed in 9.13 and agreed to get labwork and ekg done.

INPATIENT REASSESSMENT 6/20/12:
Since arriving on 19W last night, Mr. Hale has been calm and quiet, noted to be somewhat affectively flat. On interview with his primary team this morning, he was much the same as on admission. He was terse, irritable, guarded, required significant encouragement to elaborate on his responses, nevertheless was coherent, logical, goal-directed. The content of his statements was mainly remarkable for externalization and an oppositional stance. He said he was hospitalized because he is